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An Examination of the Relationship Between Several Therapist - Patient Variables and the Adequacy of the Therapeutic Relationship.

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AN EXAMINATION OF THE RELATIONSHIP BETWEEN SEVERAL
THERAPIST-PATIENT VARIABLES AND THE ADEQUACY
OF THE THERAPEUTIC RELATIONSHIP

A Dissertation

Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
in partial fulfillment of the
requirements for the degree of
Doctor of Philosophy

in

The Department of Psychology

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ABSTRACT

The present study reports an attempt to examine the relationship between several characteristics of therapists and their patients in the framework of the therapeutic relationship.

Fifteen psychotherapists and their patients served as subjects in the investigation. Each subject was asked to describe himself, his ideal self, himself as he was in a therapy session and to predict the self-description of the other person in the relationship by using a Q-sort technique. The therapy session mentioned above was observed through a one-way vision mirror. The observer described the therapist and patient using the technique above and described the relationship using Fiedler's Ideal Relationship Q sort.

Stable statistical relationships were found between the adequacy of the relationship and (1) congruence, (2) adjustment, (3) ability of the patient to perceive his therapist objectively, (4) ability of the therapist to trust and identify with his patient, (5) ability of the therapist to be less defensive and more comfortable in the relationship. A stable relationship was also found between congruence and adjustment. No relationship was found between the therapist's ability to form an adequate relationship and his ability to predict his patient's self-description.

CHAPTER I

INTRODUCTION

The therapist's personality is recognized as a critical factor in psychotherapy with schizophrenic patients, both in analytic (2, 23, 24, 12) and non-analytic literature (3, 21, 28). Carl Rogers, e.g., in a symposium at Southeast Louisiana Hospital, presented a paper entitled "A Theory of Psychotherapy with Schizophrenics and a Proposal for its Empirical Investigation" (21). In this paper, Rogers referred specifically to congruence in the therapist as a vital factor in effective psychotherapy. Others (3, 17) have also emphasized the importance of personal characteristics of the therapist in their research. To Rogers, congruence ". . . means that within the relationship the therapist is freely and deeply himself, with his actual experience accurately represented by his awareness of himself. It is the opposite of presenting a facade, either knowingly or unknowingly" (20, p. 97). For the psychotherapeutic treatment of schizophrenic patients this concept appears to be a quantifiable counterpart of Federn's insistence on the importance of complete frankness and honesty (6). Thus, one of the concerns of the present study was to define this concept operationally and to examine its relevance to the therapeutic process.

Equal to the therapist in importance for psychotherapy

is the therapeutic relationship, the channel through which the therapist works to effect changes in the patient. Although a great deal has been written about this relationship (18, 29), research is needed to define what constitutes an effective therapeutic relationship. With one notable exception (20), few studies attempt to define the factors necessary to a therapeutic relationship. The purpose of the present study is to examine certain characteristics of the psychotherapist in the framework of the therapeutic relationship.

Questions that now arise are: What personal characteristics are relevant to the therapist's ability to form a therapeutic relationship? For that matter, what constitutes a good therapeutic relationship? Finally, after these things have been determined, how can they be measured?

Personality of the Therapist

A good deal of effort has been expended in attempts to answer the question as to what characteristics of therapists are important for psychotherapy (12, 28). A study of psychotherapists at the Menninger Clinic (17) suggested that several personality characteristics could be used to differentiate the more competent from the less competent therapists. Among these were: sensitivity to others, independence in thinking and judgment, subdued in warmth, quite rather than expressive, able to express himself appropriately, and conventionally adjusted.

A study with special relevance to the subject of psychotherapy with schizophrenics is that by Betz and Whitehorn (3). These investigators found that improvement in schizophrenic patients is most likely to occur when:

1. The physician indicates in his diagnostic formulation some grasp of the personal meaning and motivation of the patient's behavior.
2. The physician selects personality oriented goals rather than psychopathology-oriented goals.
3. The physician makes use of "active personal participation."

Rogers (20) postulated six conditions which, if they exist and continue over a period of time, would be sufficient to produce change of a therapeutic nature. Among these conditions are three which pertain to the therapist:

1. He must be capable of experiencing an empathic understanding of the client's frame of reference and communicate this understanding to the patient.
2. He must experience unconditional positive regard for the client.
3. In the relationship, he must be congruent or integrated.

Since therapist congruence is one of the variables to be examined in the present study, it is important to

examine the concept more closely. Two levels of personality congruence have been defined theoretically by Barrett-Lennard (1). The first level is the consistency between total experience and conscious experience, the second level is the degree of consistency between awareness and overt expression. The second level of congruence decreases as the person in an interpersonal relationship finds it necessary to adopt defensive techniques and to obscure expression of his true feelings.

The therapist's feelings toward the patient (often referred to as countertransference) offer another avenue by which to study the psychotherapist's contribution to the process of therapy. Berman, writing about the therapist's feelings toward his patients says, "Actually most analysts' positive feelings for their patients involve a wider range of feeling whose totality we shall describe as dedication. It is dedication in this wider sense and in the sense of the dedication of the good leader and good parent that makes an analyst's attitude of kindly acceptance, patience, and so on, genuine and effective" (2, p. 161). Sechehaye (24) and Rosen (23), though working with much more disturbed patients than are seen by the average therapist, have described much the same sort of feeling.

Fiedler (9) has described a method for quantification of certain therapist attitudes toward patients.

Though this study must be interpreted with caution due to the small number of subjects used, it was successful in quantifying certain countertransference attitudes and suggests that some of these attitudes, notably accepting the patient to be a person like oneself and being supportive to the patient, seemed related to therapeutic effectiveness.

The therapist's own personal adjustment is another characteristic which has drawn critical attention. Although their own personal adjustment is a matter of great concern to therapists, particularly to beginners in the field, Hathaway says, "I wish I could believe these theoretical formulations we have been hearing or believe even some of the smaller points - for example, that a therapist should be himself well adjusted and consistent. We all know that honest appraisal of some foremost therapists would indicate doubt of that point" (14, p. 90). Seeman (25) in an opinion poll of experienced therapists found very high agreement that psychotherapy should be made available to prospective psychotherapists but found no substantial agreement on whether the most effective therapists are the best adjusted ones. The present study seeks to explore this area and attempts to furnish further evidence bearing on the role that therapist adjustment plays in the therapeutic relationship.

Therapeutic Relationship

The second of the three questions posed above--What is a therapeutic relationship?--leads to a continually expanding literature. Fiedler (7, 8), previously investigated the "Ideal" therapeutic relationship by using Q sorts. This procedure, developed by Stephenson (27) requires that the concept being assessed be characterized by sorting statements into several piles according to the degree to which the statement seems representative of the concept. This technique is otherwise known as "inverted" or "obverse" factor analysis (19). It uses persons instead of tests as variables, tests instead of persons for populations, and deals with correlations between persons instead of between tests. Q-technique, then, is a method whereby persons can be correlated, as contrasted to the more usual application of correlation where tests are correlated. In Q-technique a population of descriptive statements is ranked into a certain number of categories in accordance with the applicability of the statement to the object to be described. The number of statements placed in each category is in accordance with a normal probability curve.

Linson and Nichols (16) have investigated the reliability of Q-sort personality descriptions and found reliabilities ranging from .72 to .83 under forced sort conditions. Stephenson (27) reports reliabilities on the order of .80. In addition, Linson and Nichols concluded

"The sorter is his own worst critic and therefore the experimenter should not be unduly alarmed by disparaging self-evaluation of the method by sorters and, insofar as the sorter is a poor judge of his own responses, the dictum that the 'comfortableness' or 'naturalness' of the judging task are critical desiderata for acquiring valid data should be re-examined" (16, p. 165).

In his investigation, Fiedler found that:

1. "Therapists of different schools (Freudian, Adlerian and Non-Directive) do not differ significantly in describing their concept of a therapeutic relationship.
2. The ability to describe this concept is probably a function of expertness rather than theoretical allegiance.
3. Non-therapists can describe the ideal therapeutic relationship in the same manner and about as well as therapists. The therapeutic relationship may therefore be but a variation of good interpersonal relationships in general" (7, p. 245).

In another study, Fiedler (8) found that one factor appeared which clearly differentiated experts from non-experts. This factor was related to the therapist's ability to understand and communicate with the patient, and the therapist's own security and emotional distance from the

patient.

Discussion of the therapeutic relationship would be incomplete without some reference to the patient's attitudes and feelings toward the therapist, sometimes called transference. It is particularly in this area, however, that caution should be exercised in trying to abstract from research with neurotic patients variables that will also apply to psychotherapy with schizophrenics. The patient's feelings and attitudes toward his therapist represent to Silverberg, "a repetitious attempt to learn how not to be helpless or powerless in a situation which originally found us so" (26, p. 309).

Fiedler and Senior (11) used Q-sorts to explore feelings and attitudes in therapist-patient pairs and found that:

1. Those therapists held in higher regard by their colleagues tend to be less self-satisfied than poorer therapists.
2. The better the therapist, the more the patient tends to see him as an ideal.
3. The greater the similarity of the patient to the therapist's ideal, the less the therapist tends to like or empathize with the patient.
4. The more self-satisfied the patient the less does he feel that his therapist is better adjusted than he.

5. The more the therapist resembles, in the patient's eyes, the patient's ideal, the less does the patient feel the therapist to be maladjusted like himself.

An answer to the third question mentioned earlier-- "How can these variables be measured?"--leads directly to methods used in the experiment and the measuring instruments themselves.

CHAPTER II

THE INVESTIGATION

It is the purpose of this study to determine by means of Q-sort technique, relationships between the attitudinal characteristics of both therapists and patients and the "excellence" of the therapeutic relationship.

Hypotheses

The first group of hypotheses center around the concept of therapist congruence discussed previously. Senior and Fiedler (11) used what is in effect a partial measure of Type A congruence, a correlation between "self" and "ideal self" Q sorts. The investigators conceptualized this measure as "self-satisfaction" and found it to be negatively related to effectiveness of psychotherapists as they were rated by their peers. The present study utilized the same measure of Type A congruence but, in agreement with Rogers, will hypothesize that both Type A and Type B congruence show a direct relationship with the "excellence" of the therapeutic relationship.

Specifically, the hypotheses are:

1. Self-satisfied (congruent A) therapists are capable of forming better therapeutic relationships than their less content peers.

2. Those therapists in whom the agreement between awareness and overt expression is high (congruent B) are capable of forming better therapeutic relationships than their less self-aware peers.

The second group of hypotheses centers around the adjustment of the therapist:

3. Better adjusted therapists form better therapeutic relationships than do those less well adjusted.
4. In better adjusted therapists, the consistency between awareness and overt expression is higher than in less well adjusted therapists.

The third group of hypotheses is concerned with the interplay of feelings between therapist and patient:

5. In better interpersonal relationships, the patient believes his therapist to be close to what he himself would like to be, more closely than is objectively warranted.
6. In better interpersonal relationships the therapist tends, more than is objectively warranted, to regard his patient as being different from what he himself would like to be.
7. Therapeutic relationships involving self-satisfied patients are less excellent than relationships with patients who are dissatisfied with themselves.

8. The therapist who is capable of forming a good therapeutic relationship is also accurate in predicting the patient's evaluation of himself.
9. Patients who are involved in better therapeutic relationships see their therapists as people who are unlike themselves.
10. Therapeutic relationships involving a patient who is very similar to what the therapist himself would like to be are poorer than those relationships where this condition does not exist or exists in lesser degree.

Subjects

Subjects of this study were therapist-patient pairs composed of social workers, psychologists, and their patients from mental hospitals and clinics in the Louisiana and Mississippi area. Only patients who were capable of doing Q sorts as described in the Introduction were accepted for this study, making it necessary to reject regressed psychotic patients and children. All patients, however, were diagnosed as being schizophrenic. Each subject's time for participation was about four and a half hours, and fifteen therapist-patient pairs were used. Appendix F gives additional information about the therapists and patients.

Method of Procedure

The method employed was as follows: All subjects (patients and therapists) were asked to do three Q sorts. The subject's first sort was one of himself as he is; next, one of his ideal self; and finally one predicting the "self" sort of his therapist or patient. This required, for example, that the patient do sorts: (1) as he is, (2) as he would like to be, and (3) a sort predicting the therapist's "self" sort. (Statements used in this Q sort appear in Appendix B, directions in Appendices C, D, and E and a summary of the development of the list of statements in Appendix G).

After the sortings were made the therapist and his patient held a therapeutic session in a room with a one-way vision screen, wired for sound. After the session the therapist and patient were each asked to do a Q sort describing himself as he felt during that session. An observer, having watched the session, described each participant using the Q-sort technique and, in addition, described the quality of the therapeutic relationship with the instrument developed by Fiedler. (Statements used in Fiedler's Q sort appear in Appendix A, a summary of the development of the list of statements appears in Appendix G).

Data Analysis

The main variable for the study, adequacy of the

therapeutic relationship, was measured by correlating the Q-sort distribution describing the therapy session with the quality values given to these statements (as described in Appendix G), by Fiedler. This degree of correlation serves as a score or index for the individual therapist-patient performance, and is the main criterion variable against which all other variables will be tested.

In the first set of hypotheses, those concerned with congruence, hypothesis I, Type A congruence (self-satisfaction) was measured by means of correlating the person's "actual self" and "ideal self." Hypothesis II, Type B congruence was measured by the correlation between the person's sort of himself "as he was in the session" and the observer's corresponding sort. The second set of hypotheses, those dealing with the relationship between "personal adjustment" and adequacy of the relationship were examined by deriving Dymond's adjustment score from the therapist's self-sort. (See Appendix G for discussion of the development of this score). The third group of hypotheses, those relating to transference and countertransference attitudes, were tested as follows:

Hypothesis V: This hypothesis in better relationships, as measured by Fiedler's Q sort, patients believe their therapists to be close to what they themselves would like to be, is a complex one. The correlation between the therapist's "self" and the patient's "ideal self" provides

an index of how similar the therapist is to what the patient himself would like to be. The correlation between the patient's prediction of the therapist's "self" and the patient's own "ideal self" provides an index of the degree to which the patient's concept of the therapist approximates the patient's ideal.

If the therapist's representation of himself was found to be actually similar to the patient's ideal self these two coefficients should be similar in magnitude. If the patient's concept of the therapist's self should be an exaggeration--that is, if transference of a certain type tends to be strong then the second of these two coefficients will be larger than the first. Thus, the difference between the two coefficients may be considered to represent the degree of exaggeration. Fiedler calculated this degree of exaggeration by subtracting the squares of the coefficients. This subtraction procedure was followed in the present study.

Hypothesis VI: In better relationships, as measured by Fiedler's Q sort, therapists tend, more than is objectively warranted, to regard their patients as being different from what they themselves would like to be. The rationale used to derive a measure of this variable was identical to that used in hypothesis V. The patient's similarity to the therapist's ideal was obtained by correlating the patient's "self" with the therapist's "ideal

self." The correlation between the therapist's "ideal self" and his prediction of the patient gives an index of the degree to which the therapist's concept of the patient approached his own ideal. The degree of exaggeration was obtained by subtracting the squares of the two coefficients.

Hypothesis VII: Therapeutic relationships involving self-satisfied patients are poorer than relationships with patients who are dissatisfied. The correlation between the patient's "self" and "ideal self" sorts was used to assess the patient's degree of self-satisfaction.

Hypothesis VIII: Therapists who are capable of forming better therapeutic relationships are also more accurate in predicting the patient's evaluation of himself. The correlation between the therapist's prediction of the patient's "self" sort and the patient's "self" sort was used as an index of the therapist's accuracy.

Hypothesis IX: Patients who are involved in better therapeutic relationships see their therapists as people who are unlike themselves, more so than is objectively warranted. The rationale used to derive a measure of the variable is identical to that used in hypothesis V. The "real" similarity between the therapist and patient was obtained by correlating the self sort of each. Then the patient's assumed similarity to the therapist was obtained by correlating the patient's "self" sort with his prediction of the therapist's "self." The degree of

exaggeration was obtained by subtracting the squares of the two coefficients.

Hypothesis X: Therapeutic relationships involving a patient who is very similar on the basis of his Q-sort to what the therapist himself would like to be are poorer than those relationships where this condition does not exist or exists in lesser degree. The correlation between the therapist's "ideal self" and the patient's "self" sort was used to assess the patient's similarity to what the therapist would himself like to be. For each of the above hypotheses, the correlation taken to measure the variable was transformed to Fisher's "Z" score, and Pearson product-moment correlations were performed with the "Z" scores of the index of adequacy.

CHAPTER III

RESULTS

Correlation between Q-sorts

(A) Adequacy of relationships

Pearson coefficients of correlation between the observer's impression of the session and the sort provided by Fiedler for an ideal therapeutic relationship for each of the fifteen pairs of subjects were found to range from $-.18$ to $.89$, with a median of $.57$. Thirteen of the 15 coefficients were significant at or beyond the $.05$ level of probability, twelve at or beyond the $.01$ level. Most of the relationships were thus found to be close to Fiedler's criterion of effectiveness.

(B) Congruence, Type A

Correlations between the actual self and the ideal self ranged, for the therapists, from $.09$ to $.80$, with a median correlation at $.72$, and for the patients, $-.57$ to $.70$, with a median correlation of $-.21$. The therapists as a group were more self-satisfied or congruent than the patients. If we assume that a coefficient should be positive and at least at the $.05$ level to express congruence, then two therapists and ten patients failed to meet this standard.

(C) Congruence, Type B

Correlations between the observer's description of the therapist and the therapist's description of himself as he was in the therapy session were found to range from .51 to .77, with a median correlation at .55. All of the fifteen coefficients are significant beyond the .05 level of probability, fourteen at or beyond the .01 level. None of the correlations were negative. Thus a high level of Type B congruence was found throughout the group.

(D) Degree to which a person's estimate of his partner in a therapeutic situation approximates his own ideal

Correlations between the ideal self and prediction of the patient ranged, for the therapists, from $-.72$ to $.81$, with a median of $-.19$. For the patients the correlation between ideal self and prediction of the therapist's "self" sort ranged from $-.41$ to $.89$, with a median at $.53$. The majority of these correlations were significant at or beyond the .01 level of probability. Most of the therapists coefficients were negative as contrasted with a majority of positive coefficients for the patients. In other words, while therapists conceived of their patients as quite unlike what they themselves would like to be, patients find in their therapists a fair representation of their own ideal.

(E) Degree to which a person's self approximates the ideal of his partner in the therapeutic situation

Correlations between the actual self of therapists and the ideal self of patients ranged from $-.35$ to $.72$, with a median at $.46$; correlations between the actual self of patients and the ideal self of therapists ranged from $-.47$ to $.55$, with a median of $-.09$. A majority of the coefficients of correlation between the therapist's self and the patient's ideal self and therapist's ideal self were negative. Thus, if the actual self and ideal self sorts can be interpreted as somehow representing reality, therapists actually resemble what patients would like to be and, conversely, patients at least partially resemble what therapists would not like to be.

(F) Therapists' accuracy of prediction

Correlations between the therapist's prediction of the patient and the patient's self ranged from $-.34$ to $.68$, with a median at $.38$. Of the fifteen coefficients, thirteen were significant beyond the $.05$ level of probability, ten were significant beyond the $.01$ level, one was not significant and one was significant beyond the $.01$ level in a negative direction. Thus, the majority of the sample of therapists were quite accurate in predicting their patients' self sort.

(G) Actual resemblance between therapists and patients

Correlations between the actual self sorting of the therapist and patient in each of the fifteen pairs ranged from $-.29$ to $.54$, with a median at $.03$. The majority of these coefficients were not significant. In other words, there was little actual resemblance between the therapists and patients in this sample.

(H) Degree to which patients' estimate of therapists approximates that of their own selves

Correlations between the patient's actual self and prediction of therapist ranged from $-.45$ to $.47$, with a median at $-.04$. Half of these correlations were negative and few reached the level of statistical significance. Thus, patients in this sample did not conceive of their therapists being markedly like or unlike themselves.

Table I presents coefficients for the individual hypotheses. Inspection of this table reveals a moderately significant relationship between adequacy of the therapeutic relationship and Type A congruence, Type B congruence, Dymond's adjustment score, Patient's exaggerated idealization of the therapist, and Therapist's exaggerated idealization of the patient.

Significant at a somewhat more stable level was the correlation between adequacy of the therapeutic relationship and the therapist's tendency to conceptualize the patient as being similar to what he himself would like to be. The correlation between Dymond's adjustment score and

TABLE I

Pearson Product-Moment Correlations for Fifteen Pairs of
Subjects as Tests of Ten Specific Hypotheses

Hypothesis	Variables	r	P
1	<u>Congruence</u> A and <u>Adequacy</u>	.44	.05
2	<u>Congruence</u> B and <u>Adequacy</u>	.47	< .05
3	<u>Adjustment</u> and <u>Adequacy</u>	.47	< .05
4	<u>Adjustment</u> and <u>Congruence</u> B	.67	< .005
5	Patient's exaggerated idealization of therapist and <u>adequacy</u>	.41	< .10
6	Therapist's exaggerated idealization of patient and <u>Adequacy</u>	.48	< .05
7	Patient self-satisfaction and <u>Adequacy</u>	.22	NS
8	Therapist's accuracy of prediction and <u>Adequacy</u>	.02	NS
9	Patient's exaggerated conception of difference between himself and therapist and <u>Adequacy</u>	.10	NS
10	Patient's actual similarity to therapist's ideal self and <u>Adequacy</u>	.51	.025

Type B congruence was significant at a quite stable level, but the remaining relationships failed to approach statistical significance.

Although a number of the results were statistically significant, the relatively small number of subjects on which they were based limits the freedom with which one may generalize. In particular, since the patients involved were diagnosed schizophrenic, comparison of these results with Fiedler's should be undertaken with caution.

CHAPTER IV

DISCUSSION

The first hypothesis stated that "self-satisfied" therapists were capable of forming better therapeutic relationships than their less content peers. This hypothesis was confirmed. Correlation between the therapist's self and ideal-self was conceptualized as partially representing Barrett-Lennard's Type A congruence. Confirmation of this hypothesis lends support to Rogers' contention that congruence is a factor within the therapist which bears on his ability to form therapeutic relationships.

The confirmation of this hypothesis was at variance with results previously reported by Fiedler and Senior (11). Using a Q-sort and criterion for therapeutic adequacy different from those used in the present study, Fiedler and Senior found self-satisfaction to be negatively related to therapeutic effectiveness. In order to make the results of the present study more nearly comparable with Fiedler's, it was necessary to use the same criterion for therapeutic adequacy. Consequently, the therapists in this study were ranked in order of their therapeutic effectiveness by three of their peers and this pooled ranking correlated with therapist's "self-satisfaction." The resulting correlation (.33)

was not significant at a stable level. Though this coefficient was positive, its instability lends support to one possible explanation of the difference in results mentioned above, i.e., that reputation among one's peers and the ability to form a therapeutic relationship resembling Fiedler's ideal relationship may be independent estimates of therapeutic competence.

Parenthetically, it should be mentioned that the peer ratings discussed above turned out to be extremely unstable. With only one therapist was there complete agreement between the raters. The differences between peer ratings of the therapists in this sample ranged from 0 to 6 with a mean difference of 3.5.

The second hypothesis stated that therapists in whom the agreement between awareness and overt expression is high are capable of forming better therapeutic relationships than their less self-aware peers. This hypothesis was also confirmed. Since consistency of this type was a fairly comprehensive portrayal of congruence, the results were interpreted as rather strong evidence in support of Rogers' viewpoint.

Type B congruence as defined implied a lack of defensiveness, a freedom from the necessity to maintain a self concept inconsistent with the person's appearance to others. The question immediately arose,

was Type B related to Type A congruence? The correlation obtained between the two types of congruence (.66, $P .005$) strongly suggests that they are related.

It would be interesting to see how this lack of defensiveness related to a therapist's feeling of discomfort. Since we have already obtained an estimate of the therapist's defensiveness, the logical next step was to develop an index of the discomfort experienced by the therapist. In order to do this it was necessary to make several assumptions.

It was possible that when a therapist's self and ideal self entered unequally into the role he took in the therapy session, effort would be needed in order to maintain certain parts of the personality and keep other parts unexpressed, in other words, to maintain personality defenses. Further, as the stress this difference created increased, more effort would be needed to maintain these defenses with a resultant increase in the therapists discomfort. If this reasoning was tenable, the difference between (1) the correlation of the therapist's self and his description of himself in the therapy session and (2) the correlation of the therapist's ideal self and his description of himself in the session would provide an estimate of the effort expended by the therapist and the subjective discomfort he feels.

Correlation of this estimate of the therapist's discomfort with the estimate of defensiveness (.37, P .10) suggested that there was a relationship but this relationship failed to reach a stable level statistically. It appeared that a lack of defensiveness probably implied less subjectively felt discomfort but the relationship was not dependable.

The estimate of therapist discomfort was then compared with the estimate of the adequacy of the relationship. The resulting correlation (.80, P .001) strongly suggested that level of discomfort was important to the therapist's ability to form relationships, better relationships being more easily formed when the therapist did not find it necessary to expend a great deal of energy maintaining personality defenses.

Perhaps this level of discomfort in the therapist affects relationships with neurotics less than relationships with severely disturbed people. However, even with neurotic patients, when the therapist finds it necessary to put energy into defenses, it is likely that this may affect the quality of the relationship.

The third hypothesis that better adjusted therapists form better therapeutic relationships than their less well adjusted peers was confirmed. Though these results were

suggestive, the measure of adjustment used in this study lacked the comprehensiveness one would wish and the size of the sample is, of course, not large enough to permit a thorough test of this hypothesis.

The fourth hypothesis was that in better adjusted therapists the consistency between awareness and overt expression was higher than in less well adjusted therapists. Confirmation of this hypothesis at a stable level suggested that congruence probably plays an important role in personal adjustment as well as in therapeutic effectiveness.

The fifth hypothesis that in better relationships patients exaggerated the similarity between what they themselves would like to be, and their therapist's "self" failed to reach a stable level of significance. The results tended to go in the direction specified by the hypothesis. As will be recalled, actual similarity between the therapist's "self" and the patient's "ideal self" was rather high.

Since patients failed to exaggerate significantly this similarity the question arose, were patients in better therapeutic relationships able to see their therapists more objectively? In order to test this, a comparison of the patient's prediction of the therapist "self" sort and the observers sorting of the therapist should give an index of the degree to which the

patient perceived his therapist in an objective manner. The resulting correlation with quality of the therapeutic relationship (.66, $P .005$) offered evidence affirming this relationship.

The sixth hypothesis, that in better treatment relationships therapists tended to exaggerate the difference between their patients and what they themselves would like to be was reversed at a fairly stable level. In the population used in the present study, therapists who were capable of forming better therapeutic relationships were those who overestimated their patients similarity to what they themselves would like to be. One might speculate that these therapists were able to trust and respect their patients more than therapists who underestimated this relationship. It would seem likely that therapists who were able to approach their patients in this manner should be both less defensive and more comfortable in their therapy sessions.

Correlation of this tendency to exaggerate and the index of defensiveness confirmed the first speculation above at a stable level (.63, $P .01$). Correlation of this with the estimate of discomfort discussed above confirmed the second assumption (.66, $P .005$). These results strongly suggested that in the population used for this study, therapists who were able to trust and respect their patients were not only less defensive and

more comfortable in their therapy sessions but were able to form better therapeutic relationships.

It thus seems likely that in situations where the therapist was able to trust and respect his patient, identification with the patient was facilitated and the therapist found it easier to experience what Rogers calls "unconditional positive regard" (20, p. 98) and also would find it easier to be what Rosen calls a "loving omnipotent protector and provider for the patient" (23, p. 8).

Considered from another point of view these findings suggested that therapists experience much more difficulty in forming adequate therapeutic relationships with patients who manifest extremely impulsive, extremely disorganized, bizarre or psychotic behavior. These findings are paralleled by the clinical observation that a great majority of therapists experience difficulty in treating psychopaths and psychotics. Both of these diagnostic categories are widely at variance from most therapists' ideals of acceptable behavior.

The seventh hypothesis which stated that therapeutic relationships involving self-satisfied patients were poorer than relationships with patients who were more uncomfortable was not confirmed. The results were in the direction predicted by the hypothesis but failed to attain a stable level of significance. These findings suggested that the

patients degree of self-satisfaction is not one of the more important variables relating to the ability of the therapist and his patient to work out an effective relationship.

The eighth hypothesis advanced the idea that therapists who were capable of forming better therapeutic relationships were also more accurate in their prediction of the patient's evaluation of himself. This hypothesis was not confirmed. For the population used in this study there was no relationship between the therapist's ability to form an adequate relationship and his ability to predict his patient's self-description. If it may be assumed that prediction of the patient's Q-sorts is related to diagnostic skill, this finding would support the belief that diagnostic and therapeutic understanding involve different skills (15, p. 103; 28, 3).

This concept has important implications for training of future therapists and, if confirmed in more comprehensive studies, suggests a shift from the present day diagnostically oriented approach to understanding mental disorder to an approach which accents therapeutic understanding. Needless to say, the area surrounding therapeutic understanding promises to be a rewarding area of research.

The ninth hypothesis that patients who are involved in better relationships tend to see their therapists as people who are unlike themselves was not confirmed. In this population there appeared to be little relationship between

the adequacy of the therapeutic relationship and the patient's distortion of his therapist. On the contrary, in the discussion of hypothesis five it will be recalled that patients involved in better therapeutic relationships were able to perceive their therapists with less distortion than did patients involved in poorer relationships.

At first glance, these findings may appear to be at variance with analytic theories of transference. The classical theories state that whatever the patient's reaction to the therapist, this reaction is not related to the therapist's personality, but is the patient's reaction to the significant person that the therapist represents in the patient's past. Furthermore, effective treatment centered around development and subsequent analysis of the patient's distortion of the therapist.

Several factors seem to be relevant here. Initially, the classical theories of transference were developed from situations in which the therapist allowed little of his personality to enter into the treatment situation. There is obviously a great difference in the therapeutic situation in classical psychoanalysis and the therapeutic situation on which the results of the present study are based. Therapists in this sample sat face to face with their patients; interaction between therapist and patient was, for a considerable portion of the time, quite marked. There is relatively little psychoanalytic literature dealing with

what happens to the transference situation when the therapist brings himself into the treatment. Possibly the only place where literature of this type is found grows out of the treatment of schizophrenics. Sechehaye (24) and Rosen (23) have found it necessary and desirable to bring a large part of their own personalities into the treatment sessions. In other words, transference may be one of the areas where it is particularly dangerous to attempt to apply theories developed from patients comprising neurotic populations to the study of schizophrenics.

As a second part, psychoanalytic ideas concerning neutrality of the therapist and theories of transference and their place in treatment are still in the process of change. Silverberg (26), for example has limited the concept of transference to specific situations and, in so doing, has implied that the patient experiences genuine feeling in some of his approaches to the therapist.

Third, whatever bearing the present results have on psychoanalytic theories of transference, these results have suggested that the most effective therapeutic relationships were those in which the therapist projected himself into the therapeutic situation.

The tenth hypothesis stated that therapeutic relationships involving a patient who was very similar to what the therapist himself would like to be, were poorer than those relationships where this condition did not exist reached

statistical significance in the opposite direction. Evidently, for this population, the patient's similarity to the therapist's ideal was important somehow in the formation of a better relationship. The speculation was advanced in the discussion of hypothesis VI that therapists found it easier to respect and trust patients that fitted these conditions and consequently could be more at ease and less defensive in the relationships.

Criticisms of this Study

An obvious criticism of this study is the small size of the population. With such a small population, generalization of the results obtained is necessarily somewhat limited. At the present time, however, small studies such as this one may be useful to suggest areas for more comprehensive research.

Another criticism centers around interpretation of the Q sorts and the correlations between Q sorts. The great majority of this interpretation is speculative and must be regarded as hypotheses for future research.

Another criticism centers around the lack of control of several variables, notably the observer's familiarity with the therapists and a few of the patients used in the study. Familiarity certainly enters into the observer's description of the therapist as he was in the session, and may possibly enter into his use of Fiedler's sort. The manner in which it enters is not clear, a therapist who was unfamiliar to

the observer was described quite accurately and, more surprisingly, a therapist with whom the observer was quite familiar was described rather poorly. At any rate, an effort should be made to control for this factor in future research.

Suggestions for Future Research

The technique of observing a therapeutic interview used in this study promises to be a rewarding one. Subjectively, the observer has a much stronger feeling for what occurred during the session than when only tape recordings are used. Also, somewhat surprisingly, observation of a therapy session does not occasion unmanageable anxiety in either therapist or patient, with the possible exception of paranoid patients. After a few minutes, both the therapist and patient seem to forget that the observer is there, particularly when the therapist's relationship with the observer is a non-threatening one. It would be very interesting to follow the course of the therapeutic process at intervals with this technique. It would be especially interesting to start beginning therapists in this situation and observe the changes as the therapist becomes more experienced.

Another line of research would be to compare the population of therapists used in this study with the population used by Fiedler. Several differences in the results

obtained from the two populations are badly in need of explanation. Then, research is necessary in order to test the interpretations given to the Q-sort interrelationships. Finally, and perhaps of greatest importance, is the confirmation or refutation of the results obtained in this study by means of a longitudinal study of the progress of therapy using the same method of observation and measurement.

CHAPTER V

SUMMARY AND CONCLUSIONS

The present study reports an attempt to examine the relationship between several personality characteristics of therapists and their patients in the framework of the therapeutic relationship. These characteristics include therapist congruence, adjustment of the therapist and distortion of the patients' and therapists' perception of each other. Several hypotheses were advanced regarding the relationship between these factors.

Fifteen psychotherapists and their patients served as subjects in the investigation. The sample was composed of clinical psychologists and social workers. Included were staff members and trainees in the two professions.

All subjects were asked to describe themselves, their ideal selves, themselves as they were in a therapy session and predict the self-description of the other person in the relationship by using a Q-sort technique. The therapy session mentioned above was observed by means of a one-way vision mirror in a room wired for sound. The observer described the therapist and patient using the technique above and described the therapeutic relationship using Fiedler's Ideal Relationship Q sort. The relationships between descriptions were used to test hypotheses.

Concerning the major hypothesis of the study, the following conclusions are drawn:

(1) Congruence is a factor in the therapist which bears on his ability to form therapeutic relationships.

(2) Therapists in whom the agreement between awareness and overt expression is high are capable of forming better therapeutic relationships than therapists in whom this condition does not exist. This condition appears to be fairly accurate portrayal of congruence. The results then can be interpreted as fairly strong evidence in favor of Rogers' viewpoint.

(3) Better adjusted therapists form better relationships than do their less well adjusted peers.

(4) In better adjusted therapists the consistency between awareness and overt expression is greater than in less well adjusted therapists.

(5) In better relationships the patient is more able to see his therapist objectively, without any self-imposed distortions.

(6) When conditions are such that therapists find it easy to trust and identify with their patients, therapists are less defensive, more comfortable and able to form more adequate relationships. Conversely, therapists find difficulty in forming therapeutic relationships with patients who are widely different from what the therapists themselves would like to be.

(7) The patient's degree of self-satisfaction is not one of the more important variables relating to the ability of the therapist and patient to work out an effective relationship.

(8) There is no relationship between the therapist's ability to form an adequate relationship and his ability to predict his patient's self-description.

(9) The final conclusion based upon the main findings is that the method used in this study to examine psychotherapeutic factors holds considerable promise for future research.

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APPENDICES

APPENDIX A

Statements from Fiedler's Ideal Relationship Q sort

Category 7 (most characteristic of an ideal relationship)
Therapist is able to participate completely in the patients communication.

Category 6 (very characteristic of an ideal relationship)
The therapist's comments are always right in line with what the patient tries to convey.

The therapist is well able to understand the patients feelings.

The therapist always follows the patients line of thought.

The therapists tone of voice conveys the complete ability to share the patients feelings.

The therapist sees the patient as a co-worker on a common problem.

The therapist treats the patient as an equal.

Category 5 (somewhat characteristic of an ideal relationship)

The therapist reacts with some understanding of the patients feeling.

The therapist is able to keep up with the patients communication much of the time.

The therapists reactions are in neither particularly favorable or unfavorable in permitting free communication by the patient.

The therapist usually maintains rapport with his patient.

The therapist is usually able to get what the patient is trying to communicate.

The therapist usually catches the patients feeling.

The therapist is never in doubt as to what the patient means.

The therapists remarks fit in just right with the patients mood and content.

The therapist is interested but emotionally uninvolved.

The therapists feelings do not seem to be swayed by the patients remarks.

The therapist maintains a friendly, neutral attitude throughout.

The therapist shows little positive or negative emotion in his reactions to the patient.

The therapist seems to like the patient.

The therapist is pleasant to the patient.

The therapist lets the patient determine the course of the session.

The therapist gives and takes in the situation.

The therapist acts neither superior or submissive to the patient.

The therapist treats the patient like a friend.

Category 4 (middle category)

The therapist often flounders around before getting the patients meaning.

The therapist often misses the point the patient is trying to get across.

The therapists comments tend to divert the patients trend of thought.

The therapists understanding of the patients feelings is neither particularly good nor particularly bad.

The therapist at times draws emotionally away from the patient.

The therapist occasionally makes the patient angry.

The therapist feels somewhat tense and on edge.

The therapist seems to be a little afraid of the patient.

The therapist accepts all of the patients statements in a noncommittal manner.

The therapist is pleased with the patient.

The therapist is trying to establish an emotionally close relationship with the patient.

The therapist sympathizes with the patient.

The therapist greatly encourages and reassures the patient.

The therapist expresses great liking for the patient.

The therapist is deeply moved by the patient.

The therapist tries to sell himself.

The therapist seems hesitant about asking questions.

The therapist readily accedes to the patients wishes.

The therapist assumes an apologetic tone of voice when commenting.

The therapist tries to please the patient.

The therapist acts toward the patient in a somewhat protective manner.

The therapist treats the patient like his pupil.

The therapist directs and guides the patient.

Category 3 (somewhat inapplicable)

The therapist somehow seems to miss the patients meaning time and time again.

The therapist reacts in terms of his own problems.

The therapist is unable to understand the patient on any but a purely intellectual level.

The therapist finds it difficult to think along the patients lines.

The therapist is rejecting to the patient.
 The therapist is somewhat cool towards the patient.
 The therapist showers the patient with affection
 and sympathy.
 The therapist treats the patient like an honored
 guest.
 The therapist treats the patient with much defer-
 ence.
 The therapist curries favor with the patient.
 The therapist always apologizes when making a re-
 mark.
 The therapist tends to look down on the patient.
 The therapist talks down to the patient as if he
 were a child.
 The therapist is very condescending to the patient.
 The therapist puts the patient in his place.
 The therapist gives the impression of feeling very
 much above the patient in social and intellectual status.

Category 2 (uncharacteristic)

The therapist cannot maintain rapport with the
 patient.
 The therapists own needs completely interfere with
 his understanding of the patient.
 The therapist feels disgusted by the patient.
 The therapist feels hostile toward the patient.
 The therapist is punitive.
 The therapist is very unpleasant to the patient.
 The therapist acts in a very superior manner to the
 patient.

Category 1 (least characteristic of an ideal relationship)

The therapist shows no comprehension of the feelings
 that the patient is trying to communicate.

APPENDIX B

Butler and Haigh Q Sort

1. I feel uncomfortable while talking with someone.
2. I put on a false front.
3. I am a competitive person.
4. I make strong demands on myself.
5. I often kick myself for the things I do.
6. I often feel humiliated.
7. I am much like the opposite sex.
8. I have a warm emotional relationship with others.
9. I am an aloof, reserved person.
10. I am responsible for my troubles.
11. I am a responsible person.
12. I have a large feeling of hopelessness.
13. I live largely by other peoples values and standards.
14. I can accept most social values and standards.
15. I have few values and standards of my own.
16. It's difficult to control my aggression.
17. Self control is no problem to me.
18. I am often down in the dumps.
19. I am really self-centered.
20. I usually like people.
21. I express my emotions freely.
22. Usually in a mob of people I feel a little bit alone.
23. I want to give up trying to cope with the world.
24. I can live comfortably with the people around me.
25. My hardest battles are with myself.
26. I tend to be on guard with people who are somewhat more friendly than I expected.
27. I am optomistic.
28. I am just sort of stubborn.
29. I am critical of people.
30. I usually feel driven.
31. I am liked by most people that know me.
32. I have an underlying feeling that I am not contributing enough to life.
33. I feel helpless.
34. I can usually make up my mind and stick to it.
35. My decisions are not my own.
36. I often feel guilty.
37. I am a hostile person.
38. I am contented.
39. I am disorganized.
40. I feel apathetic.
41. I am poised.
42. I just have to drive myself to get things done,

43. I often feel resentful.
44. I am impulsive.
45. It's important for me to know how I seem to others.
46. I don't trust my emotions.
47. It's pretty tough to be me.
48. I am a rational person.
49. I have a feeling I'm just not facing things.
50. I am tolerant.
51. I try not to think about my problems.
52. I have an attractive personality.
53. I am shy.
54. I need somebody to push me through things.
55. I feel inferior.
56. I am no one. Nothing really seems to be me.
57. I am afraid of what other people think of me.
58. I am ambitious.
59. I despise myself.
60. I have initiative.
61. I shrink from facing a crisis or difficulty.
62. I just don't respect myself.
63. I am a dominant person.
64. I take a positive attitude towards myself.
65. I am assertive.
66. I am afraid of full-fledged disagreement with a person.
67. I can't seem to make up my mind one way or the other.
68. I am confused.
69. I am satisfied with myself.
70. I am a failure.
71. I am likeable.
72. My personality is attractive to the opposite sex.
73. I have a horror of failing in anything I want to accomplish.
74. I feel relaxed and nothing really bothers me.
75. I am a hard worker.
76. I feel emotionally mature.
77. I am afraid of sex.
78. I am naturally nervous.
79. I really am disturbed.
80. All you have to do is just insist with me and I give in.
81. I feel insecure within myself.
82. I have to protect myself with excuses, with rationalizing.
83. I am a submissive person.
84. I feel intelligent.
85. I feel superior.
86. I feel hopeless.
87. I am self-reliant.
88. I often feel aggressive.

- 89. I am inhibited.
- 90. I am different from others.
- 91. I am unreliable.
- 92. I understand myself.
- 93. I am a good mixer.
- 94. I feel adequate.
- 95. I am worthless.
- 96. I dislike my own sexuality.
- 97. I am not accomplishing.
- 98. I doubt my own sexual powers.
- 99. I am sexually attractive.
- 100. I have a hard time controlling my sexual drives.

APPENDIX C

Instructions to Subjects

Please sort these 100 statements so that they best describe the way your patient _____* will describe himself. This is not meant to be your estimate of the patient but your estimate of the way the patient describes himself. Sort the cards into eleven categories of 2, 4, 6, 10, 16, 24, 16, 10, 6, 4, and 2 statements each, so that the two cards which best describe the way the patient describes himself are on one extreme of the distribution, the four next most descriptive statements are in the second pile, and so on. The two statements which the patient sees as least characteristic of himself will then be on the other extreme of your sorting. You will find the number in each category on the envelopes in which the cards are to be placed. There should be no cards left over. Be sure you place the proper number in each envelope.

*Insert patients name.

APPENDIX D

Instructions to Subjects

Please sort these 100 statements so that they best describe your ideal self. Sort them into eleven categories of 2, 4, 6, 10, 16, 24, 16, 10, 6, 4 and 2 statements each, so that the two statements which describe your own ideal best are on one extreme of the distribution, then the four next most description statements are in the second pile, and so on. The two statements which are least characteristic of your own ideal will then be on the other extreme of your sorting. You will find the number in each category on the envelopes in which the cards are to be placed. There should be no cards left over. Be sure you place the proper number in each envelope.

APPENDIX E

Instructions to Subjects

Please sort these 100 statements so that they best describe you. Sort them into eleven categories of 2, 4, 6, 10, 16, 24, 16, 10, 6, 4 and 2 statements each, so that the two statements which describe you best are on the extreme of the distribution, then the four next most descriptive statements are in the second pile, and so on. The two statements which are least characteristic of you will then be on the other extreme of your sorting. You will find the number in each category on the envelopes in which the cards are to be placed. There should be no cards left over. Be sure you place the proper number in each envelope.

APPENDIX F

Personal Characteristics of Therapists and Patients

Thirteen of the therapists in this sample were male, two were female. The therapists' ages ranged from 27 to 41 with a median at 32. Eight of the therapists had received more than 100 hours of personal therapy, one had received 40 hours of personal therapy and six had received no personal therapy. Six of the therapists had supervised others in psychotherapy and nine of the therapists had done no supervision. Six of the therapists held the Ph.D. degree in psychology, eight of the therapists held the M.A. degree in psychology and one of the therapists held a Masters in Social Work. Twelve of the therapists had done more than 200 hours of therapy under supervision, one of the therapists had done 125 hours of therapy under supervision, one had done 15 hours and another eight hours of therapy under supervision. Eight of the therapists claimed a psychoanalytic orientation and the remainder were Sullivanian, Eclectic and Rogerian.

The patients' ages ranged from 15 to 42 with a median at 32. Eight of the patients were male, seven were female. Seven of the patients had been in the hospital less than ten months, three had been in the hospital more than 24 months and five of the patients had been in the hospital between 10 and 18 months. Eight of the patients had received Electroconvulsive therapy, four had received Insulin Coma therapy,

eight of the patients had received drug therapy and one of the patients had received no somatic therapy. Ten of the patients were diagnosed Schizophrenic reaction, Undifferentiated type; three of the patients were diagnosed Schizophrenic reaction, Pseudoneurotic type; one was diagnosed Schizophrenic reaction, Paranoid type and one was diagnosed Schizophrenic reaction, Catatonic type. All of the patients had received more than 15 hours of psychotherapy, four of the patients had received more than 170 hours of psychotherapy and one of the patients had received more than 1000 hours of psychotherapy.

APPENDIX G

Development of Q Sorts and Adjustment Score

Used in this Study

In developing his Q sort, Fiedler (7) began by assuming that the therapeutic relationship could be conceived of as consisting of three dimensions: (a) the therapist's ability to communicate with and understand the patient, (b) the emotional distance which the therapist takes toward the patient and (c) the status of the therapist in relation to the patient. Each dimension was given twenty-five statements and each dimension was in turn subdivided into groups of five statements representing five steps on each dimension. Next, to refine the selection of items, (1) a number of therapists had to agree concerning the aspect of the relationship tapped by the statement and the intensity of the statements in order to make sure they had the same meaning to a number of therapists.

The statements obtained by this selection procedure were then sorted by a group of ten persons composed of untrained laymen, expert and non-expert therapists from psychoanalytic, non-directive and Adlerian orientations. The resultant correlations were factor analyzed and, since only one general factor emerged, the ratings of the four

therapists with the highest factor loadings were pooled to select the statements for the final Q sort. Fiedler reports a test-retest reliability of .92 for this group of statements. Test-retest reliabilities in the present study ranged, for seven of the 15 therapists, from .58 to .89 with a median of .68. These reliabilities were obtained by correlating the observer's description of the relationship at the time of the observed therapy session with his description of the relationship as it appeared from the tape recording made of the therapeutic session.

A second Q sort used here to assess characteristics of the therapists and patients was developed by Butler and Haigh and used in the studies on psychotherapy at the University of Chicago Counseling Center (22). This Q sort consists of 100 statements taken at random from available therapeutic protocols. The nature of the items to be sorted may be suggested by these illustrations: "I am a hard worker;" "I really am disturbed;" "I am a rational person;" "I am afraid of what other people think of me."

Dymond (5) developed from the Butler and Haigh Q sort an adjustment score. In order to develop this index, Dymond gave the Q-sort statements to two well-trained practicing clinical psychologists who were not client-centered in their professional orientation and asked them to sort the statements into two piles, those the

well-adjusted person should say are like himself and those a well-adjusted person should say are unlike himself. The judges disagreed on only two of the 100 items. Next, after removal of the items on which the judges disagreed and the items which the judges agreed did not relate to a person's adjustment, the statements were given to four other judges to sort in the same way. Again the agreement between the judges' ratings was very high, only one judge differing on as many as four items. Thus, seventy-four of the original one hundred statements have been categorized according to whether they were like or unlike a well-adjusted person. A final requirement is to score the person taking the sort.

Using this index of adjustment, a group of persons presenting themselves for therapy were found by Dymond to be less well-adjusted than a group who did not ask for treatment. After treatment there was significant improvement in the experimental group which was, then, not different from the no-therapy group. In addition, there was a significant agreement between counselor's opinions of the success of therapy and the final adjustment as measured from self-description.

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